Witness Name: Dr Shermin Imran
Exhibits:
Date:13th November 2025

THE SOUTHPORT INQUIRY

SECOND WITNESS STATEMENT OF
DR SHERMIN IMRAN

INTRODUCTION

Dr Shermin Imran

1. I am Dr Shermin Imran, MBBS, FRCPsych, GMC No: 5183861, Consultant Child & Adolescent Psychiatrist and Lead Consultant for Forensic Child and Adolescent Mental Health Services North West (FCAMHSNW). I am employed by Greater Manchester NHS Foundation Trust (GMMH), based at Prestwich Hospital, Manchester, M25 3BL.

2. I trained as a Specialist Child and Adolescent Psychiatrist and approved clinician under Mental Health Act and have been working as a Consultant Psychiatrist at GMMH Child and Adolescent Mental Health Service (CAMHS) since 2008, for 10 years as an in-patient psychiatrist and over the last 7 years as a psychiatrist within FCAMHSNW. I have experience of working as a Lead Psychiatrist for CAMHS at GMMH and have also volunteered as an advisor for NHS England and the Royal College of Psychiatrists. I am an approved trainer and continue to train psychiatrists in CAMHS at GMMH. There has been no change in my role since this incident.

3. I provide this statement in response to the request from the Inquiry for written evidence following the oral testimony of Ms Amanda-Jayne Brown on 21

October 2025. During her evidence, Ms Brown indicated that certain matters would be more appropriately addressed by me, and I have therefore been asked to respond to the specific points set out in the Inquiry Solicitor's letters dated 22 and 29 October 2025.

Responsibility for Structured Risk Assessments

Ms Brown was asked to clarify the current state of play regarding which agency bears responsibility for conducting structured risk assessments (e.g. SAVRY) in cases involving high-risk young people. The Chair noted that there appears to be ongoing uncertainty, including among experienced clinical leads, about how this responsibility is allocated and coordinated. Please provide a detailed explanation of the current FCAMHS position on this issue, including how responsibility is determined, shared, or escalated across agencies.

4. Responsibility for case management and holding an up to date risk assessment remains with the referring agency and lead community professional for young people referred to and accepted by FCAMHS, informed by their local procedures and policies. This is clinically important as the community agency holds the ongoing up to date information as part of their case management, to inform risk assessment and management, which is a dynamic process.

5. The role of FCAMHS is to provide advice and support to community agencies in relation to risk assessment so as to adapt this in line with the needs of the young person, which may include use of SAVRY (Structured Assessment of Violence Risk in Youth), a national structured risk assessment tool.

6. SAVRY is designed to be used as an aid ~~or~~ to guide professional risk assessment and intervention planning for management of violence in youth. A substantial proportion of existing research in relation to SAVRY has been conducted on 12 to 18 year old males and it is accepted that further research is required to clarify its applicability across genders and different ethnic groups (Randy Borum et al, Professional manual- SAVRY). For young people who may be neurodiverse, specific factors relating the diagnosis may also need to be

considered. Professionals who have been trained or have an understanding of SAVRY will keep in mind the dynamic risk and protective factors described in SAVRY to inform their risk assessment process, whilst adapting the overall risk assessment to the individual context of a young person.

7. Where a direct assessment is carried out by FCAMHS, with the young person and their carers/parents, the FCAMHS assessor considers whether SAVRY could be used as an appropriate tool for the particular case. If SAVRY is formally used as part of the direct assessment, the FCAMHS practitioner will then author and complete the SAVRY, taking into account the information shared during the course of assessment, from various sources including from the young person, their carers and professionals involved in their care. This is then shared with the community professionals.

8. The responsibility to update and review the risk assessment at regular intervals or as and when risk changes, remains with the community lead professional. FCAMHS continues to provide advice and support whilst the case is open or via a re-referral at a later stage if the case is closed to FCAMHS.

9. In cases where FCAMHS provides only consultation and advice to the community professionals relating to a young person referred to FCAMHS, the responsibility to author and update the risk assessment remains with the referring agency who are involved in direct assessment of the young person in the community. Where the FCAMHS practitioner and community professionals consider and agree, during the consultation, that SAVRY could be formally included as a useful tool to enhance the current risk assessment held by the community team, the community professional involved in direct assessment of the young person and family e.g. CAMHS or Youth Justice may agree to author and complete SAVRY, collating and using the relevant information from their assessment. FCAMHS will remain involved in an advisory role using a partnership approach to enhance professionals' skills, for example, in completing the factorial analysis, formulation and/or recommendations from SAVRY. The service specification for FCAMHS supports and encourages

working within a partnership approach with community professionals also to develop skills and confidence within the wider workforce.

10. If the community practitioners do not have the skills and knowledge to undertake a SAVRY, the FCAMHS practitioner would consider a direct assessment with the young person and their carer, including completion of SAVRY as part of their assessment. FCAMHS practitioners will discuss the case at this stage with the MDT. The FCAMHS practitioners will work collaboratively with community practitioners to review and update the SAVRY in line with any changes to the young person's risk assessment whilst the case is open to FCAMHS ~~following the conclusion of FCAMHS involvement~~ and ensure they are aware of the option to re-refer to FCAMHS if there are any significant changes in risk and further support is required later on.

Criteria for Transition from Consultation to Assessment

Ms Brown referred to a revised Standard Operating Procedure (SOP) that sets out clearer mechanisms for moving from consultation to forensic assessment. Please confirm the criteria now used to determine when a case should progress to formal assessment, and who makes that decision within FCAMHS.

11. The FCAMHS SOP outlines the mechanism for moving from consultation to forensic assessment being used by the FCAMHS team at present. (SOP 9.1 Decision to Assess).

12. FCAMHS clinicians may choose to undertake a forensic assessment following a consultation if one of the following is met:
    - From the information provided in the consultation, the clinical presentation is complex, with many aggravating mental health, neurodevelopmental and social factors, and the practitioner cannot develop a robust formulation of the young person's difficulties and forensic behaviours, without undertaking an assessment.

- There is disagreement between professionals involved in the consultation; a direct assessment is the only way to resolve this.
- The young person requires a specialist assessment, which only FCAMHS can suitably provide.
- There is a formal request from the local referring system which indicates that a specialist assessment is warranted

The practitioner will present the case at the weekly MDT meeting, and attendees will consider the following:

- Does the young person meet the criteria described above?
- Would additional information and consultation enable a formulation and recommendations to be developed?
- Are there any barriers to undertaking an assessment that needs to be resolved before an assessment can occur (i.e., does the young person have matters before the court which would be considered sub judice)?
- Are there any specific risks to undertaking an assessment?
- Are FCAMHS the most suitable service to undertake this assessment?
- Does the assessment require the skill set of particular practitioners in the team?
- Are any specific assessment tools or psychometrics required, i.e., a cognitive assessment?

13. If the MDT decides to assess the young person, the practitioner will record this in the progress notes, inform the external lead professional for the young person and commence arrangements for the assessment.

Use and Application of SAVRY

The Inquiry is seeking clarity on how the SAVRY tool is currently used within (consultation SAVRY authored by others when requested e.g. advice on factor analysis and or recommendations and formulation- authored by community professional in that case and completed and shared by them with relevant stakeholders etc) FCAMHS, including:

a. Who completes the scoring?

To score the SAVRY, the assessor rates 24 risk items and 6 protective items using a 3-level system (Low, Moderate, High) for risk and a binary system (Present, Absent) for protective factors. For clinical purposes, these individual scores are not summed into a single number; instead, the rater uses them to make a professional judgment about overall severity of the risk at that time. For research, total scores are calculated by summing the risk items and protective items separately.

In a case where a full SAVRY is completed the nominated author completes the rating. This may be an FCAMHS practitioner where they have agreed to complete the SAVRY as part of their direct assessment with the young person and parent/carer as well as the professionals involved with the family. This may well be a community clinician for example from in-patient or community CAMHS team or Youth Justice who has agreed to author the SAVRY.

b. How multidisciplinary input is gathered

If FCAMHS is completing the SAVRY, information is gathered via consultation with the professionals involved in the case who hold historical and current information relating to risk and they are asked to share their own risk assessment and other relevant documents including incident logs, clinical letters, meeting minutes etc. In cases where FCAMHS has completed a direct assessment with the young person and their carers, information is also gathered from direct interview with the young person and their carer/parent.

c. How the results are used to inform risk management and intervention planning

A completed SAVRY would offer a formulation which is an understanding of the young person's risks informed by SAVRY. The tool also includes exploration of the young person's protective factors which can be used to support development of a safety plan. Following completion of the SAVRY recommendations will be provided, for example relating to supervision and

safety planning and options for specific treatment mitigating risk and enhancing protective factors.

d. Please provide a summary of current practice and relevant guidance or protocols

(Please see above, answer to question 1 and reference to FCAMHS SOP and FCAMHS service specification by NHSE).

4. Escalation Procedures When Agencies Do Not Engage sec 17 page 15

Ms Brown indicated that FCAMHS now has escalation procedures when key agencies (e.g. CAMHS) do not attend multi-agency meetings. Please outline the escalation process, including thresholds for action and how FCAMHS ensures appropriate engagement from system partners.

14. The FCAMHS SOP describes the escalation process currently used by FCAMHS practitioners (FCAMHS SOP- point 17).

15. During case involvement, concerns may arise that services or professionals are not operating in an expected manner, which directly impacts on the safety of the young person or others or may lead to poor outcomes for the young person. Examples of this may include but are not limited to:
    - Decision-making that may lead to an adverse outcome.
    - Barriers to accessing a particular service or intervention, e.g., referral rejection, no service capacity, long waiting lists, etc.
    - Safeguarding concerns.
    - Ineffective communication practices.
    - Failing to implement recommendations or complete immediate actions
    - when key agencies (e.g. CAMHS) do not attend multi-agency meetings.

16. Where such concerns arise practitioners will attempt to resolve concerns where appropriate via the consultative process; however, if this is ineffective or the concerns are serious or could lead to significant harm, the practitioner will complete an incident report and escalate the matter to the Team Manager, who

will raise it formally with their equivalent in the service involved. If the concern cannot be resolved, the Team Manager will escalate to senior operational leads within the CAMHS Division i.e. Service Manager and/or Head of Operations and, if required, safeguarding leads.

17. If an internal escalation within the CAMHS Division has failed to resolve the concern, the Service Manager will contact the commissioning Quality Leads within the Lead Provider Collaborative, who will support an escalation via the locality commissioning pathways

Post-discharge Monitoring and Audit

Ms Brown stated that FCAMHS now conducts audits and has more robust discharge protocols. Please provide details of the post-discharge monitoring system, including how cases are tracked, how re-referrals are prompted, and how audit findings are used to improve practice.

18. After careful consideration of the changes described by Ms Brown, the FCAMHS team currently considers discharge carefully for each case as an MDT. At the final consultation meeting, the FCAMHS case manager will check with the attendees at the consultation that they concur with the decision for FCAMHS to discharge the case and the practitioner explains the process for making a further referral to FCAMHS in the future. This decision is recorded in the final discharge letter. A second FCAMHS practitioner, who has not been involved in the case, reviews the discharge letter and the decision to discharge. If the second practitioner concurs with the decision to discharge, this is recorded in the clinical record, and the discharge is progressed. In cases where the practitioners disagree, the discharge decision will be taken to the weekly multi-disciplinary team meeting for further discussion. In case of any concerns, for example about recommendations that could not be progressed in line with expectations, the practitioner discusses the case with the MDT and may keep the case open to provide continued support, as required. This also enables any ongoing clinical and confidential information shared with FCAMHS to be stored safely within the EPR (electronic patient records) of an open case.

19. FCAMHS is not able to undertake post discharge monitoring of the cases which have been closed by the team. The onus is on the system and the community practitioners who are continuing to support the young person to re-refer to FCAMHS if they have any further concerns. It is noteworthy that the FCAMHS team may not have access to up to date information relating to risk and progress of the case after the case closure as clinical records are often held within separate systems across organisations and not necessarily accessible to FCAMHS.
20. At the point of discharge, the FCAMHS practitioner will also clarify with the lead community professional the process to re-refer to the team should the risk change or escalate in future. The practitioner will request that their recommendations are included in the overarching management plan in the community held by the lead professional and monitored accordingly.

21. These responsibilities are described in FCAMHs SOP. (SOP- 21.1 - responsibilities of the lead community professional and 8.3 Recommendations and Actions).

22. FCAMHS established an audit process to review and improve the quality of consultation reports. The audit was designed using letter writing standards devised by the Royal College of Psychiatrists (2021) and tailored to the service. A sample of 20 anonymised reports was scrutinised against the following standards:

- Anonymised sample number
- Patient demographics: name, DOB, address
- Attendance details: date of contact
- Name and contact detail of referring healthcare professional
- Reason for referral
- FCAMHS contact details
- Prescribed medication: documented presence or absence of
- Diagnoses: documented presence or absence of
- History and discussion

- Risk profile
- Impression/formulation
- Plan: with name of the professional who agreed to action each point
- Follow up consult date or discharge date
- Date of letter
- Evidence on PARIS of receipt of letter or status of letter

23. The audit found that the majority of the letters reviewed were sent to the referrer and there was evidence that the recipient was chased if they had not confirmed receipt of the document; the letter contained the relevant contact information for FCAMHS and the professionals in attendance; the discussion at the consultation was comprehensively documented; and the letters included when the next consult, appointment and meeting was due to take place.

24. The audit found several areas where the documentation was less thorough:
    - Whether the young person was prescribed medication or not.
    - If the young person had a specific health condition or not.
    - Recommendations and actions were allocated to a specific professional or agency
    - Clear documentation of risk
    - Evidence of a clear formulation

25. To improve the quality of clinical letters, a standard letter template was developed for use by all practitioners during consultation. This template contains headings and prompts to ensure that practitioners are communicating clearly within the expected audit standards.

26. A re-audit of clinical letters has recently been completed, and a report and action plan is currently in development. Preliminary findings have shown significant improvements in the overall quality of clinical letters since the template was adopted; however, further progress is required to improve practitioners' documentation of prescribed medication and ensuring that recommendations are allocated to external agencies or professionals. The

letter template will be updated with additional prompts for the inclusion to be included in within these sections, a learning session with be conducted with team members, and an additional quality checklist will be undertaken before each letter is sent by the team administrator

Is it right to say FCAMHS fills the gap between mainstream CAMHS and forensic services? The purpose is to ensure that vulnerable young people don't fall through the cracks. In this case would you agree that AR did 'fall through the cracks'?

27. The FCAMHS service specification has been developed to provide this service to young people who may not receive a service from mainstream CAMHS, struggle to engage with this service and/or the mainstream service needs support to manage vulnerable high risk young people. Due to the size and geographical area covered by this team FCAMHS would not be able to fulfil the function of the local mainstream services entirely. However, the service remains in a good position to work in partnership with them. On reflection, and noting the evidence from other services, the reasons for AR's deterioration seem complex and multifactorial, that said, it is hoped FCAMHS involvement whether ongoing from first referral or re-involvement at a later date, as advised by FCAMHS, may have supported the network in strengthening their formulation and risk assessment & management plans. It is important to note however that robust interagency working would have remained contingent on each agency fully participating in the process and taking responsibility for their own part in the process to co-operate with the lead community agency.

You explain that the allocated FCAMHS practitioner will engage with professionals to gather pertinent information to formulate a structured narrative. Does that mean that because FCAMHS is not a 'case holding' service those in FCAMHS are wholly reliant on the reliability of the information made available by others.

28. The service model of FCAMHS involving consultation and advice is contingent on accurate information provided by the referrer and other community agencies.

Furthermore, direct information from the young person and their parent/carer can be gained, where required, to add to the overall picture which is contingent on consent provided by the young person and their parent/ carer to meet with FCAMHS and their ability to provide accurate information at that time.

29. Therefore, FCAMHS practitioners request information from a variety of sources to mitigate the risk of missing or incorrect information and try to clarify any gaps in information provided during the consultation process. This highlights the importance of sharing (and recording) accurate information as far as possible in a timely manner across agencies. FCAMHS' own practice of sharing our letters only with the referrer and asking them to share this with other professionals, as required (practice at the time when AR was open to FCAMHS) has been changed to share the letters with all professionals involved with the consultation.

Does a narrative, by its very nature, depend upon an individual's interpretation? Should there be a more formalised structure in place? If so, how do you envisage that could be done?

30. Whilst a narrative provided by a professional or a young person or their carer is likely to be in part their interpretation of the events, this is kept in mind during both the consultation and assessment process. This issue in itself may not be unique to FCAMHS work and can be encountered potentially both during the consultation and assessment process. Factors formally and informally mitigating this risk include requests by FCAMHS for agencies to share their reports, meeting minutes and care plans as well as FCAMHS involving and listening to a variety of agencies as far as possible (involved at the time with young person) to be able to hear a variety of narratives.

31. Furthermore, where a conflict of views is observed as a factor complicating the consultation and/or assessment, FCAMHS practitioners use the expertise of the wider FCAMHS team, discussing the case and seeking further support and opinion from the wider team. Where difference of opinion between agencies

may be deemed a barrier to progress, the option of escalating this issue ~~w~~in line with the agreed escalation structure within the service, and where required commissioners, can also be employed.

Is it right that the responsibility for risk management and care planning remains with the referrer and so any support provided by FCAMHS is done through the prism of someone else's assessment? Does that bring with it risk where there is lack of professional curiosity?

32. Responsibility for developing and updating the risk assessment and care plans, remains the ongoing responsibility of the referrer and lead professional. This is crucial as risk assessment is often a dynamic process and, at times, a prompt response may be needed, for example in a crisis, or to a significant change in situation, without necessarily the need for interface with a regional agency like FCAMHS which is only available Monday-Friday, 9am-5pm.

33. Furthermore, ownership of the risk and care planning by the referring agency, informed by their policies and procedures, is vital for timely response and their accountability to the young person and their carer.

34. From an FCAMHS perspective, it is important the risk assessment and care planning completed by other agencies is fully shared with FCAMHS to inform their advisory function and consideration of any need for further assessment e.g. a structured risk assessment and/or recommendations to strengthen the care plan further. However, it is the responsibility of the FCAMHS practitioner to maintain their professional curiosity and raise issues in consultation where up to date risk assessments and care plans could not be shared by the referring agency at the time and/or raise the issue of any gaps in the plans shared during consultation, bringing them to the table to develop these further, including via FCAMHS' work with the agencies.

Is it possible for FCAMHS to take ownership of cases where there is a need for specialist knowledge? How and in what circumstances would that take place?

Should that be a consideration of your practitioners and if so, should it be recorded in documentation form?

35. FCAMHS is not commissioned to take over case management from local community agencies. However, after discussion with the wider MDT within FCAMHS, they may choose to become more involved in a case -such as by conducting direct assessments and sharing their observations during consultations, alongside existing information. FCAMHS can also offer ongoing support over a longer timeframe, if necessary, but this must be balanced carefully. There is a risk that local agencies might reduce their involvement, assuming the regional specialist agency has taken over, even though FCAMHS may not be able to provide the same local interventions and support for which the local agency is actually commissioned.

36. In summary, where initial consultation raises the need for further understanding of risk and difficulties presented by the young person beyond what is expected from the local agencies to complete, the FCAMHS practitioner can bring this to the wider MDT, record their concerns and make a plan accordingly to support the case.

FCAMHS has no authority to require that their recommendations are implemented, so as a service they are wholly reliant on others taking any action they recommend?

37. This is correct.

How, in those circumstances, can you measure the success of the service providing (for example, are you providing the right information, is it being actioned, if not, why not etc?)

38. During subsequent consultations FCAMHS reviews the progress of community agencies against the recommendations agreed in the previous meetings and records this in the consultation letter shared with all the agencies involved. Where an FCAMHS practitioner has concerns about gaps in information or

accuracy of information (compared with other sources) or recommendations not being progressed they will raise this in the consultation and try to clarify and offer support.

Where there is a recommendation, for example, a psychological assessment or psychological intervention what should be done to see that the appropriate service receives that recommendation? Can FCAMHS provide that service?

39. A recommendation, such as a psychological assessment or intervention, is discussed in consultation and shared with the responsible community agency in both consultation and written correspondence. FCAMHS is not commissioned to deliver direct interventions to young people and their families though are able to provide support to local agencies in partnership to enable them to do this where possible (Please see FCAMHS service specification).

40. On occasions where a specific specialised intervention or assessment is not available locally the lead professional ~~may~~ can escalate this to their commissioners to source this from an external provider through their usual procurement process.

Do you consider that threatening or carrying out violence by a person under 18 years is a high-risk activity?

41. We consider this to be a high risk activity.

Do you consider that resource pressures mean that FCAMHS often focus on what are considered to be the 'highest-risk cases' which leaves gaps for those with emerging but serious needs? If that is the case, what can be done to resolve this?

42. The FCAMHS national service specification was developed to provide advice and support not only to those young people who are already known to the youth justice system due to their high risk, but also to provide this service for young

people about whom agencies like health, education and social care have concerns of risky behaviours arising and escalating over time.

43. The FCAMHS service model was designed therefore to focus on providing consultation and advice to a number of community agencies involved with young people, about whom they have concerns- across a wide geographical region, as quickly as possible. Assessment of specific cases can then follow, e.g. to expand on the current understanding of their needs and risks and to provide specific recommendations spanning across agencies to meet the young person's needs and mitigate the risks (e.g. by appropriate safety planning as well as fostering protective factors etc).

44. The FCAMHS team continues to accept referrals for, and works with, young people who are already considered high risk as well as those with emerging and escalating concerns. We are therefore able to currently accept referrals for both groups without a waiting list, however the working model requires robust functioning of all agencies involved with the care of young people, for example, to be able to actively take part in professional consultation and take forward any recommendations agreed with them.

45. The lead community professional being able to co-ordinate the care of a young person robustly working with multiple agencies, and each agency reflecting and regularly auditing their own input, should also help the model to deliver the aims.

46. Where needed, training and support for an agency to undertake robust case management should be available from their line manager or the relevant organisation, as such availability of case management training and ongoing supervision on a national level may help to strengthen this role.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed: **Signature**

Full name: Dr Shermin Imran

Dated: 13th November 2025